

# REQUEST FOR APPROVAL OF OUTSIDE ACTIVITY\*

(Ref.: HHS Standards of Conduct Regulations)

<input type="checkbox"/>	Initial Request
<input type="checkbox"/>	Revised Request
<input type="checkbox"/>	Renewal

1. NAME (Last, First, Initial)	2. ORGANIZATIONAL LOCATION (Operating Division, Bureau, Division)
3. TITLE OF POSITION	4. GRADE AND SALARY (Federal) -
*5. NAME, ADDRESS AND BUSINESS OF PERSON OR ORGANIZATION FOR WHOM OUTSIDE SERVICES WILL BE PERFORMED	6. LOCATION WHERE SERVICES WILL BE PERFORMED
7. NATURE OF ACTIVITY (Indicate type of activity, e.g., teaching, consultative services, and give full description of specific duties or services to be performed. Specify, when possible, the scheduled days of week and hours of day proposed activity will be performed.)	

8. ESTIMATED TIME INVOLVED	
a. PERIOD COVERED FROM TO	b. ESTIMATED TOTAL TIME DEVOTED TO ACTIVITY (If on a continuing basis, give estimated time per year)
c. WILL WORK BE PERFORMED ENTIRELY OUTSIDE USUAL WORKING HOURS? <input type="checkbox"/> YES <input type="checkbox"/> NO IF "NO", INDICATE ESTIMATED NUMBER OF HOURS OR DAYS OF ABSENCE FROM WORK	
9. DO YOUR OFFICIAL DUTIES RELATE IN ANY WAY TO THE PROPOSED ACTIVITY? <input type="checkbox"/> NO <input type="checkbox"/> YES (Describe)	
*10. IF PROVIDING CONSULTATIVE OR PROFESSIONAL SERVICES, ARE YOUR WOULD-BE ASSOCIATES RECEIVING OR WILL THEY SEEK, A GRANT OR CONTRACT FROM A FEDERAL AGENCY? <input type="checkbox"/> NO <input type="checkbox"/> YES (Describe)	

11. METHOD OR BASIS OF COMPENSATION <input type="checkbox"/> FEE <input type="checkbox"/> HONORARIUM <input type="checkbox"/> PER DIEM <input type="checkbox"/> PER ANNUM <input type="checkbox"/> ROYALTY <input type="checkbox"/> EXPENSES <input type="checkbox"/> OTHER (Specify)	12. WILL COMPENSATION BE DERIVED FROM A DHHS GRANT OR CONTRACT? <input type="checkbox"/> NO <input type="checkbox"/> YES (Describe)
13. THIS REQUEST IS MADE WITH FULL KNOWLEDGE OF DEPARTMENT AND OPERATING DIVISION POLICY AND PROCEDURES ON OUTSIDE ACTIVITIES. THE STATEMENTS I HAVE MADE ARE TRUE, COMPLETE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.	
14. SIGNATURE OF EMPLOYEE	15. DATE
*16. ADDITIONAL INFORMATION ATTACHED <input type="checkbox"/> YES <input type="checkbox"/> NO	

17. ACTION RECOMMENDED BY REVIEWING OFFICIAL			
a. <input type="checkbox"/> APPROVAL <input type="checkbox"/> DISAPPROVAL	b. SIGNATURE	c. TITLE	d. DATE
18. ACTION TAKEN			
a. <input type="checkbox"/> APPROVAL <input type="checkbox"/> DISAPPROVAL	b. SIGNATURE	c. TITLE	d. DATE

\*See reverse of form  
HHS-520 (Rev. 1/82)

(INSTRUCTION ON BACK OF FORM)

## INSTRUCTIONS

- \* Item 5 - Self-Employment: If applicable, indicate self-employment, the type of service (as medical, legal, etc.), whether alone or with partners, giving their names, and if providing professional services to a large number of clients or patients, estimate the total number rather than listing them separately.
  
- \* Item 10 - Federal Grants or Contracts involved: Describe the Federal grants or contracts (type, granting or contracting department, etc.). Full details must be provided on any aspect of professional and consultative services which involves, directly or indirectly, the preparation of grant applications, contract proposals, program reports, and other material which are designed to become the subject of dealings between institutions and government units and the Federal Government.
  
- \* Item 16 - Attachments: Be sure to sign copies of all attachments submitted.

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\* ITEM 17 - COMMENTS OF REVIEWING OFFICIAL

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\* ITEM 18 - REASON FOR DISAPPROVAL